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GENDER-SPECIFIC CLINICAL MANIFESTATION OF UNIPOLAR DEPRESSION

Olivera Žikić[1,2], Milena Stanković[2], Jelena Aranđelović[3]

It is well known that the incidence of depression is twice as often in women than in men. However, data about the clinical picture and the course of the disorder in men and in women are inconsistent. The purpose of our research is to find out if there are any differences in terms of symptomatology and course of unipolar depression in men and in women.

The study included 84 subjects affected by unipolar depresson, who were divided in two groups according to the gender: a group of males, comprising 20 subjects and a group of female subjects, that comprised 64 affected persons. We used the general semi-structured questionnaire with questions about the course of unipolar depression and socio-demographic data, Patient Health Questionnaire-9, Symptom Checklist-90-Revised (SCL-90-R), Cambridge Depersonalization Scale (CDS) and Beck Anxiety Inventory.

Regarding symptoms occurring within unipolar depression, there was no statistically significant gender-specific difference finding. Males tended to somewhat higher frequency of anhedonia and hostility, while females tended to more frequent sleep disturbance and decrease in energy. In terms of the course of disorder, it was found that there was a statistically significant difference in the age at the onset of disorder (M:Ž=43.9:34.72 years) and frequency of episodes (males had more frequent episodes).

Men and women, affected by unipolar depression differ in terms of the course of unipolar depression, but not in the sense of its clinical manifestation. *Acta Medica Medianae 2016;55(2):5-11.*

Key words: major depression, gender, anxiety, depersonalization

University of Niš, Faculty of Medicine,Niš, Serbia[1]
Clinic for Mental Health Protection, Clinical Center Niš, Serbia[2]
Special Hospital for Psychiatric Illness "GornjaToponica", Niš, Serbia[3]

Contact: Olivera Žikić
Clinic for Mental Health, Clinical Center Niš, Serbia
Bul. Dr Zorana Đinđića 48, 18000 Niš
Mail: okac55@gmail.com

Introduction

It is almost a common fact that depression occurs twice as often in females than in males. The prevalence of major depression during life is 21.3% for the female population and 12.7% for the male population (1, 2). Prepubescent gender ratio, when depression is concerned, is 1:1; however, after puberty, the ratio changes, and females have a higher percentage of getting ill then males. The reason for such a difference between genders is not certain yet. It is widely considered that there is a numerous biological, psychological and social factors involved in the occurrence of depression. Some of these are: the difference in hormonal systems (gender hormones and hypothalamic–pituitary–adrenal axis), childhood abuse in younger girls, the role of women in today's society, specificity in exhibition and evaluation of physical and psychological symptoms (3).

Among other things, it is also known that the attitudes towards the disease, as well as visiting the doctor because of symptoms, are different for men and women. Women are more prone to evaluating their health condition as more difficult/worse than it actually is (4), providing much more information about their somatic complaints, and assessing them as more intense than men do (5). In contrast with this, males frequently minimize their psychological complaints and verbalize a fewer number of somatic and emotional symptoms (6, 7).

In general, the largest number of research devoted to gender differences in depression pointed to precise differences in incidence and prevalence, as well as to the explanation of why this difference occurs. However, what was a matter of interest to us is whether, in addition to clinical course, there are specific differences in the clinical presentation of the disease amongst genders. Therefore, the objective of our research is to determine whether there are differences amongst genders in clinical picture, associated symptoma-

tology, course and level of functionality in unipolar depression.

Research method

The study comprised 84 subjects of both genders, suffering from unipolar depression, including both outpatient and inpatient care. The inclusion criteria were: (a) unipolar depression - both major depressive disorder (F32.0, F32.1, F32.2) or recurrent major depressive disorder (F33.0, F33.1, F33.2); (b) age 18-65; (c) that they are able to understand and answer the questionnaires; (d) that they are not psychotic; (e) without comorbid psychiatric disorder; (f) without a comorbid neurological disorder. The diagnosis was established on the bases of clinical assessment. It was also confirmed with the result of The Patient Health Questionnaire - 9 (PHQ-9) (8). Initially, one hundred patients had been tested, but due to irregularly completed questionnaires, 16 subjects were excluded from further processing. The irregularity was that the questionnaires were not filled in completely, therefore, a further processing of the results was impossible.

The group of 84 subjects was divided into two subgroups – a subgroup of males comprising 20 subjects (23.8%) and a subgroup of female subjects with 64 affected persons (76.2%). Subsequently, the subgroups were compared, with respect to the following variables:

A. Sociodemographic characteristics: (a) Place of residence, (b) Partnership status, (c) Age of subjects.

B. Actual clinical picture of depressive disorders and associated symptoms: (a) sadness, (b), anhedonia (c) lack of energy, (d) sleep disturbance, (e) an appetite changes, (f), suicidal ideation, (g) a negative view of themselves, (h) lack of concentration, (i) a change of psychomotor manifestations (j) anxiety, (k) depersonalization, (l) somatization, (m) obsessive-compulsive symptoms, (v) interpersonal sensitivity, (o) hostility (p) phobic symptomatology, (r) paranoid ideation (s) psychoticism.

C. Other features: (a) age of the patients at the onset of the disease, (b) the frequency of episodes, (c) a reactive onset of the disease, (d) previous suicide attempts, (e) functionality.

In order to obtain the necessary data, the following questionnaires were applied:

A. General semi-structured questionnaire. With this questionnaire, we obtained the information on socio-demographic data as well as on the specific features of the disease, such as the age of the patient at the beginning of the disease, whether the first depressive episode has been associated with a stressful situation or not, the frequency of depressive episodes, the length of actual episode, as well as are there previous suicide attempts. Based on the length of the current episode, we estimated whether the depressive disorder currently had a chronic course (i.e. the duration of an episode needs to be longer than two years).

B. The Patient Health Questionnaire 9 (PHQ-9) presents the dimensional and diagnostic questionnaire for assessing depression (8). It contains nine items and each item could be rated on a 4-point scale (Not at all=0; Several days =1; More than half the days =2; Almost every day =3). There is an additional item assessing whether the disorder affects the functionality of the respondents. This questionnaire is based on the diagnostic criteria for the diagnosis of major depression (DSM-IV classification) (9). Major depression is diagnosed if 5 or more of the 9 depressive symptom criteria have been present at least "more than half the days" in the past two weeks, and one of the symptoms is depressed mood or anhedonia.The symptom is considered as positive, clinically relevant, if it is present "more than half of the days" or "almost every day", except for the item which assesses suicidality which counts as clinically relevant if present at all, regardless of its duration.

The intensity of depressivness was determined by summing the values of all nine items. Score is interpreted within the five groups of results: (a) without depression (score 0-4); (b) mild depression (score of 5-9); (c) moderate depression (score 10-14); (d) medium severe depression (score 15-19); (e) severe depression (score >20).

C. Beck Anxiety Inventory (BAI)–dimensional self-questionnaire used for anxiety intensity measurement. It contains 21 questions scored on a 4-point scale ranging from 0 (not at all) to 3 (severely expressed), and the final sum is interpreted within the three groups of results: low anxiety (0-21), moderate anxiety (22-35) and high anxiety (>36) (10, 11).

D. Cambridge Depersonalization Scale (CDS) (12) – self quesionnaire used for depersonalization symptomatology intensity measurement. It is dimensional questionnaire and the score higher than or equal 70 is an indicator of the existence of high, pathologic depersonalization levels.

E. The Symptom Checklist-90-Revised (SCL-90-R) – questionnaire, representing a list of 90 items, reflect the psychological problems and psychopathological symptoms of subjects (13). The subjects evaluate each of the symptoms on the scale from zero to four, in regard to sym-ptom prevalence during the previous week (0=not at all, 1=a little bit, 2=moderately, 3=quite a bit, 4= extrimely). By this questionnaire, we were estimating the presence or absence of associated symptomatology, as follows: somatization, opsesive-compulsive symptomatology, interpersonal sensitivity, hostility, fobic symptomatology, paranoid ideation and psychoticism. The obtained average values for each dimension are translated to T-values by special calculations. T-values exceeding 63 are considered as clinically significant, that is, the symptom is present on the clinically

significant level. Additionally, the data are obtained about the estimated severity of the disorder–global index of the symptoms severity, average severity of the symptom and average number of symptoms.

The research was conducted during 2012 and 2013 at the Clinic for Mental Health Protection, Clinical Center Niš.

Data were processed by means of statistical program SPSS 17. For continuous variables the Student's t-test was applied, for nominal and ordinary variables the exact Hi-square test. Statistical significance was set at the level $p<0.05$.

Results

A/ Sociodemographic data

In our group of subjects, males were somewhat older than women on average (M:F=49: 43.97 years), they were dominantly from rural areas (60%), and they were in a partnership relation (80%). Female subjects were dominantly from urban areas (59.4%) and they also had a partner (76%). However, there was no statistically significant difference found for the indicated variables ($p>0.05$). Therefore, the groups were equable in terms of the indicated parameters.

B/ Current clinical picture of depressive disorders and associated symptomatology

In view of the symptoms, occurring within diagnostic criteria for establishing the diagnosis of unipolar depression, a statistically significant gender-specific difference was not found. However, there is a tendency to more frequent occurrence of certain symptoms ($P>0.05$, but <0.10). Males exhibited more frequent presence of anhedonia, whereas in women, sleep disturbance and drop of energy were more present (Table 1).

There were no statistically significant differences in depression intensity (M:F=18.6: 18.28), in the intensity of associated anxiety (M:F=31: 35.47), depersonalization symptomatology (M:F= 71:79.22) (Table 3), and in functionality disturbance as well (Table 1).

Regarding the associated symptomatology, we did not establish the presence of statistically significant specific difference (Table 2). Only the tendency towards somewhat higher fre-quency of hostility in men than in women was established.

Table 1: Gender-specific difference in clinical manifestation of unipolar depression

	MALE	FEMALE			
			X^2test	df	P value
ANHEDONIA			3.56	1	0.081
not present	2 (10%)	20 (31.3%)			
present	18 (90%)	44 (68.8%)			
SADNESS			2.019	1	0.328
not present	0 (0%)	6 (9.4%)			
present	20 (100%)	58 (90.6%)			
SLEEP DISTURBANCE			3.36	1	0.088
not present	6 (30%)	8 (12.5%)			
present	14 (70%)	56 (87.5%)			
ENERGY DROP			3.36	1	0.088
not present	6 (30%)	8 (12.5%)			
present	14 (70%)	56 (87,5%)			
DISTURBED APPETITE			0,21	1	0.770
not present	4 (20%)	16 (25%)			
present	16 (80%)	48 (75%)			
NEGATIVE SELF-IMAGE			0.21	1	0.790
not present	8 (40%)	22 (34.4%)			
present	12 (60%)	42 (65.6%)			
CONCENTRATION DISTURBANCE			0.197	1	0.772
not present	6 (30%)	16 (25%)			
present	14 (70%)	48 (75%)			
PSYCHOMOTOR DISTURBANCE			0.04	1	1.000
not present	8 (40%)	24 (37.5%)			
present	12 (60%)	40 (62.5%)			
SUICIDAL THOUGHTS			1.005	1	0.407
not present	12 (60%)	46 (71.9%)			
present	8 (40%)	18 (28.1%)			
FUNCTIONALITY DISTURBANCE			2.036	1	0.217
not present	2 (10%)	16 (25%)			
present	18 (90%)	48 (75%)			

Table 2: Gender-specific and associated symptomatology in unipolar depression

	MALE	FEMALE			
			X^2 test	df	P value
SOMATIZATION			2.309	1	0.198
not present	8 (40%)	38 (59,4%)			
present	12 (60,6%)	26 (40,6%)			
OPSESIVECOMPULSIVE			1.680	1	0.156
not present	12 (60%)	48 (75%)			
present	8 (40%)	16 (25%)			
INTERPERSONAL SENSITIVITY			0.555	1	0.321
not present	14 (70%)	50 (78,1%)			
present	6 (30%)	14 (21,9%)			
HOSTILITY			2.590	1	0.096
not present	12 (60%)	50 (78,1%)			
present	8 (40%)	14 (21,9%)			
FOBIC ANXIETY			2.333	1	0.105
not present	10 (50%)	44 (68,8%)			
present	10 (50%)	20 (31,3%)			
PARANOID IDEATION			0.197	1	0.430
not present	14 (70%)	48 (75%)			
present	6 (30%)	16 (25%)			
PSYCHOTICISM			0.555	1	0.321
not present	14 (70%)	50 (78,1%)			
present	6 (30%)	14 (21,9%)			

C/ Other characteristics

When we consider the course of the disease, it was found out that there was a statistically significant difference related to age at the disease onset as well as frequency of episodes. (Table 4a and 4b). Namely, female subjects' had earlier beginning of the disorder (M:F=43.9:34.72 years) and less frequent episodes (one third of the female subjects has got one episode in a couple of or more years). The biggest percent of male subjects (70%) had very frequent episodes, or more precisely, more then one epizode during a year (Table 4b).

The other variables had no statistically important gender-specific differences. However, women had less frequent suicide attempts than men and there was more frequently present reactive begining od desease (precipated by stress). Males have more frequently chronificated course of disorder, but without statistical signifi-canse.

Table 3: Gender-specific intensity of depressiveness and anxiety

	Gender	N	Mean value	Std. Deviation	t-test	df	P value
INTENSITY OF DEPRESSIVNESS	Male	20	18.6	5.394	0.267	82	0.790
	Female	64	18.28	4.424			
INTENSITY OF ANXIETY	Male	20	31	15.721	-1.211	82	0.229
	Female	64	35.47	13.984			
INTENSITY OF DEPERSONALIZATION	Male	20	71	62.112	-0.508	82	0.613
	Female	64	79.22	63.510			

Table 4a: Gender specific characteristics of disorder

	Gender	N	Mean value	Std. Deviation	t-test	df	P value
AGE AT THE ONSET OF ILLNESS (years)	Male	20	43.9	11.064	3.039	82	0.003*
	Female	64	34.72	12.006			
LENGTH OF ACTUAL EPISODE (months)	Male	20	13.4	13.651	-0.571	82	0.569
	Female	64	17.84	33.832			

*=p<0.05

Table 4b: Gender specific characteristics of disorder

	MALE	FEMALE	X^2test	df	P value
COURSE OF UNIPOLAR DEPRESSION			0.729	1	0.393
Episodic	6 (30%)	26 (40,6%)			
Chronic	14 (70%)	38 (59,4%)			
EPISODES FREQUENCY			15.204	2	0.000*
Several times a year	14 (70%)	36 (56,3%)			
Once a year	6 (30%)	4 (6,3%)			
Once in a couple of years	0 (0%)	24 (37,5%)			
REACTIVE BEGINING OF DISORDER			0.06	1	1.000
Yes	10 (50%)	34 (53,1%)			
No	10 (50%)	30 (46,9%)			
SUICIDAL ATTEMPTS			1.578	1	0.292
Yes	10 (50%)	22 (34,4%)			
No	10 (50%)	42 (65,6%)			

*p<0.05

Discussion

Latest researches have shown that there is a certain difference in exhibiting depressive disorder in males and females. Nevertheless, the results are often not consistent.

The most frequent claim is that, in female population, there is a larger number of subjects with atypical and anxiety features of depression (14). It was found that women suffering from depression have a higher incidence of atypical symptoms such as increased appetite and weight gain (15, 16), more frequent somatization (especially painful sensations and gastrointestinal complaints), sleep disorder as well as anger and hostility (15, 17). In women, there is a perceived decline of energy potentials and heightened interpersonal sensitivity. Females with depressive disorder also have a higher number of suicide attempts than males, while males with this disorder have a higher number of realized suicides (18). Considering the occurrence of suicidal thoughts, the results are inconsistent - there are data showing that men are more prone to suicidal thoughts (15). However, there are some opposite data showing that suicidal thoughts are more common in women (19). Males have more frequent weight loss (16).

Most studies show that there is no significant difference between genders in intensity of depressiveness, except in atypical symptomatology (20, 21). Still, there are researches confirming that depressiveness is slightly more intense in females and is conjoined with a higher degree of disturbed functionality (18, 21, 22). It is noted that women with depressive disorder have more intense symptoms than males (15). However, it is considered that there is no difference in the frequency of depressive symptomatology occurrence (23).

In our research, variables addressing the clinical picture of unipolar depression were not different between genders. We perceived a tendency in male subjects to slightly more frequent rates of anhedonia and hostility, while female subject showed that tendency to sleep disorder and lack of energy. There is no perceived difference in the levels of anxiety nor severity of the depression itself. Men and women had equal frequency of reduction in functionality.

In our study, we found significant differences only in the course of depressive disease.

The differences between males and females were in the age of the beginning of the disease and the frequency of episodes. In females, the disease began earlier (around 35 years) than in males (around 44 years). This finding is consistent with data that depressive illness starts earlier in females (18). There were also differences between genders considering the frequency of depressive episodes. Males have had significantly more frequent episodes - about 70% of them reported having more episodes, during the course of one year. The course of depressive disorder with rare episodes - like a single one within a span of a couple of years - was noted only in female subjects.

The results of our study did not confirm the previous results on the differences between genders in terms of episodic or chronic course of the disease. Namely, in previous studies it has been found that women tend to have chronification of disease (24, 25). Also, even though there are data that women have more frequent suicide attempts (18) and longer episodes (1), our research showed no gender differences.

Conclusion

Based on the results of our study, we can say that symptomatology, in terms of intensity and frequency and the level of functionality, between males and females with unipolar depression shows no significant differences. The only noted differences are related to the age of the first onset of illness as well as to the frequency of depressive episodes.

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SPECIFIČNOST ISPOLJAVANJA UNIPOLARNE DEPRESIJE U ODNOSU NA POL ISPITANIKA

Olivera Žikić[1,2], Milena Stanković[2], Jelena Aranđelović[3]

Univerzitet u Nišu, Medicinski fakultet, Niš, Srbija[1]
Klinika za zaštitu mentalnog zdravlja, Klinički centar, Niš, Srbija[2]
Specijalna psihijatrijska bolnica "GornjaToponica", Niš, Srbija[3]

Kontakt: Olivera Žikić
Klinički Centar Niš, Srbija
Bul. Dr Zorana Đinđića 48, 18 000 Niš, Srbija
E-mail: okac55@gmail.com

Poznato je da se depresija oko dva puta češće javlja kod žena nego kod muškaraca. Međutim, podaci o kliničkoj slici i toku bolesti kod muškaraca i kod žena su nekonzistentni. Cilj našeg istraživanja bio je da utvrdimo da li postoje i koje su razlike u simptomatologiji i toku unipolarne depresije kod žena i muškaraca.

U ispitivanje je uključeno 84 ispitanika obolela od unipolarne depresije koji su podeljeni prema polu na dve grupe: grupa muškaraca koja je sadržala 20 ispitanika i grupa sa ženskim ispitanicima u kojoj je bilo 64 obolele osobe. Primenjeni su opšti semistrukturisani upitnici sa pitanjima o toku unipolarne depresije i sociodemografskim podacima, The Patient Health Questionnaire-9, The Symptom Checklist-90-Revised (SCL-90-R), Cambridge Depersonalization Scale (CDS) i Beck Anxiety Inventory.

Po pitanju simptoma koji se javljaju u okviru unipolarne depresije, među polovima nije nađena statistički značajna razlika. Muškarci su imali tendenciju ka nešto većoj učestalosti anhedonije i hostilnosti, dok su žene imale tendenciju ka učestalije prisutnom poremećaju sna i padu energije. Po pitanju toka bolesti utvrđeno je da postoji statistički značajna razlika po pitanju starosti na početku bolesti (M:Ž=43,9:34,72 godine) i učestalosti epizoda (muškarci su imali učestalije epizode).

Muškarci i žene oboleli od unipolarne depresije se razlikuju po toku, ali ne i po kliničkom ispoljavanju unipolarne depresije. *Acta Medica Medianae 2016;55(2):5-11.*

Ključne reči: *major depresija, pol, anksioznost, depersonalizacija*